



Youth Transplant Camp Volunteer

We welcome participation of youth without regard to race, color, religion, sex, national origin, disability, ancestry, age, income eligibility, sexual orientation, or marital or family status.

PLEASE PRINT CLEARLY

Volunteer's Name: Last _____ First _____ MI ____ **Circle One:** M F

Referred to camp by: _____

Address: Street _____

City _____ State ____ Zip _____ Phone (____) _____ County _____

School attended 2008/2009 _____ **School District** _____ **Grade next fall** ____ **Date of birth** ____/____/____

Shirt Size: (Circle One) YS YM YL S M L XL XXL

Ethnicity (Optional): Circle One: White African-Amer. Hispanic Asian Other

PARENT/GUARDIAN/FOSTER PARENT INFORMATION

1. **Parent/Guardian's/Foster Parent's name** _____

Relationship _____
Home Address: Street _____ City _____ State ____ Zip _____
Work Phone (____) _____ Cell Phone :(____) _____
Home Phone (____) _____ Email: _____

2. **Parent/Guardian's/Foster Parent's name** _____

Relationship _____
Home Address: Street _____ City _____ State ____ Zip _____
Work Phone (____) _____ Cell Phone :(____) _____
Home Phone (____) _____ Email: _____

WHY ARE YOU VOLUNTEERING FOR THIS YOUTH CAMP FOR TRANSPLANTS?

- Course Credit?
- Personal Connection to Transplant?
 - Please describe the experience or connection: _____
 - _____

HAVE YOU WORK YOUTH CAMPS BEFORE?

- No
- Yes:
 - Dates: _____ Camp: _____
 - Dates: _____ Camp: _____

PLEASE INCLUDE SIGNED COPY OF RISK & RELEASE FORM WITH THIS APPLICATION

WHAT DO YOU PERSONALLY WANT TO GET OUT OF THIS EXPERIENCE?

PARENTAL ACKNOWLEDGMENT AND CONSENT

The health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted. **Authorization for treatment:** I hereby give permission to the medical personnel selected by Joy Outdoor Education Center, LLC (JOEC) to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes; I give permission to JOEC to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by JOEC to secure and administer treatment, including hospitalization, for the person named above. I give permission to the JOEC medical staff to assist my child with over-the-counter medication if needed.

Signature of Parent/Legal Guardian _____ **Date** _____